Date: December 16, 1996 DSL-BQA-96-057

To:
Hospital	HOSP - 29
Home Health	HHA - 24
Hospice	HSPCE - 25
Ambulatory Surgery Center	ASC - 08
Physical Therapist in Independent Practice	PTIP - 06

From: Judy Fryback, Director
Bureau of Quality Assurance

Information from the Health Care Financing Administration dealing with the Addition of Sites to an Existing Provider and Provider Based Determinations.

Attached is the federal Health Care Financing Administration's Division of Health Standards and Quality Regional Program Letter No. 96-08. This letter includes attachments related to the topics described above. However, we do not include the Marion Goldman memorandum with this mailing. Instead we are including a copy of Regional Program Letter 96-04 that embodies the Marion Goldman response.

Please share this information with your staff. If you have any questions regarding this information, please call Stephen D. Schlough, P.E., Chief, Health Services Section, at
(608) 266-3878.

JF/SDS/jjf

Department of Health & Human Services
Region V
Health Care Financing Administration
105 West Adams Street
15th Floor
Chicago, Illinois 60603-6201

Refer to: CO8

September 1996

DIVISION OF HEALTH STANDARDS AND QUALITY REGIONAL PROGRAM LETTER NO. 96-08

SUBJECTS: (1) Addition of Sites to an Existing Provider
(2) Provider Based Determination

This Regional Program Letter (RPL) addresses the two topics listed above. Please refer to the attached three documents on these subjects.

ISSUE I. Addition of Sites to an Existing Provider and the Attached April 3, 1996 Memorandum from Marion Goldman, HSQB.

Regional Program Letter No. 96-04 previously addressed this memorandum. This memorandum clearly states that it is inherent in the provider certification process that providers must give the Health Care Financing Administration (HCFA) notification of any proposal to expand service areas by either adding branches, satellites or extension locations. This policy applies to all provider types, including hospitals, home health agencies, hospices, outpatient physical therapists, etc., which wish to add additional sites to their certification. The memorandum also states that there is no basis for the provider to bill Medicare for services provided from a site which has not been determined to meet applicable requirements of certification. The memorandum instructs us to consider whether the proposal: (1) meets Medicare statutory and regulatory requirements, (2) meets State and local laws, and (3) will affect if Medicare reimbursement by the proposal.

When you are informed of a change in the operation of a provider, such as the addition of branches, satellites, extension locations, or other off-site locations, you must consider these criteria and arrive at a determination as to whether the provider's proposal meets them. Advise the provider in your initial contact that Medicare reimbursement for services rendered from this added site is contingent upon HCFA approval. The issue of the impact on Medicare reimbursement and administration will be made by the HCFA Regional Office (RO) with input from the Division of Medicare and the Fiscal Intermediary (FI). Your input is necessary to determine if the first two criteria in the memorandum are met. The extent of your activity will depend on the type of provider and established certification procedures, that exist for the addition of a branch office or subunit to a home health agency, addition of an extension location to a certified rehabilitation agency, addition of an off-site outpatient department of a hospital, and etc.

After you have arrived at a decision based on your evaluation on whether the provider meets the first two criteria, submit a recommendation to the RO via a Certification and Transmittal (C&T) to approve or not to approve the additional site. Attach to the C&T a narrative explaining the basis for the recommendation. Include in your narrative the date that the site began providing services. If the location is approvable, we will approve it effective with that date. If the location does not meet the criteria initially, we will approve it effective with the earliest date that it does meet the criteria.

ACTION: Please submit to your program representative a copy of any questionnaires or check-lists you currently use in determining whether the first two criteria (e.g., for branch offices/sub-unit determinations in

home health agencies).

ISSUE 2: Provider Based Designations and the Attached Program Memorandum (PM) to the Fiscal Intermediaries, HCFA Publication No. 60A, Revision A-96-7, Issue Date of 08/96

This Program Memorandum (PM) to the Intermediaries is a positive step toward tightening the HCFA policy in an effort to ensure that the Medicare Program pays "…only for those costs that are necessary for the efficient delivery of needed health services." While this PM was sent to the FIs, the PM also applies to State agencies and the DHSQ. The PM states that determinations will be made by the appropriate HCFA RO components, i.e., the Division of Health Standards and Quality and the Division of Medicare with the assistance of the State survey agencies and the FIs.

The PM also should be viewed as an expansion of existing survey and certification instructions currently in the State Operations Manual (SOM) at Section 2024. We suggest that the PM be distributed to appropriate survey and certification staff for placement in their manuals as a supplement to Section 2024.

When you receive an application from a new provider or supplier that indicates a desire to be certified as "provider based", advise the applicant that, in addition to conducting any needed survey and certification action, you will be assisting the RO in making a determination as to whether the applicant meets the provider based criteria outlined in the attached memorandum, Section 2024 of the SOM (if applicable), and appropriate Medicare procedures and regulations.

If there is any indication that the applicant wishes to be designated as "provider-based", the surveyor should evaluate the applicant for compliance with the criteria contained in the PM at the time of the initial on-site survey. In the event that the determination is a result of a change in ownership or other action not requiring an on-site survey, it may be possible to make the determination based on telephone contact with the provider, followed by their submission of written supporting documentation.

We have attached a check-list for use in making this determination. Once you have made the determination, submit a C&T to the RO, with the completed check-list and other appropriate documentation (such as correspondence from the provider). If the determination is made at the time of an initial survey, simply include the "provider-based" determination as a part of your initial certification package.

Upon receipt of your recommendations, we will solicit input from the Division of Medicare and the FI in making a final determination.

If you have questions regarding either of these procedures, please contact your Program Representative.

/s/ Walter V. Kummer
Associate Regional Administrator
Division of Health Standards and Quality

Attachments:
1. April 3, 1996 Goldman Memorandum
2. 08/96 Program Memorandum to Intermediaries
3. Region V Check-List for Provider Based Designation

cc: Six State Survey Agencies
Six State Medicaid Agencies
Fiscal Intermediaries
Administration on Aging

HEALTH CARE FINANCING ADMINISTRATION – CHICAGO OFFICE

ELECTRONIC DHSQ REGIONAL PROGRAM LETTER #96-04 MAY 1996

SUBJECT: ADDITION OF SITES TO AN EXISTING PROVIDER

The purpose of this memorandum is to clarify the Health Care Financing Administration (HCFA) position concerning providers that expand their service areas by adding satellites, extensions, branches, and in the case of physicians, individual or group practices, or clinics to existing provider agreements or provider numbers. These provider expansions have implications for State agencies, regional offices, and intermediaries because they affect survey and certification, coverage and reimbursement.

For example, a home health agency's (HHA) proposal to add a branch to a parent agency's geographical area requires a review of the proposal and may require a survey of the branch. The proposal could also affect the HHA's rural and urban reimbursement rates. A number of situations have arisen where a provider has been overpaid because it billed Medicare for services it provided at an expansion site without notification of the existence of the site or where it did report an expansion and never received notice that it was accepted as a part of the provider. The following guidelines apply to expanded locations including a hospital's purchase of a physician's office or clinic.

It is inherent in the provider certification process that a provider give notification to HCFA of its proposal to expand its service area by adding a branch, satellite or extension location. The Medicare statute and applicable regulations are implicit that the proposed expanded service area meet the Condition of Participation the same as the primary location that has signed the provider agreement or that has been assigned a provider number or both. In the absence of notification, HCFA has no way of determining whether the requirements critical to health and safety are met at the expanded location. For example, a hospice's request for a satellite location may be denied because it cannot demonstrate how the hospice will assume administrative and supervisory responsibility for the services provided at the expansion site. Moreover, there is no basis for a provider to bill Medicare for services provided by a site which has not been determined to meet applicable requirements of participation.

When an expansion request is received, before making a determination consider the following:

() Whether the proposal meets Medicare statutory and regulatory requirements. For example, in the case of an HHA, does the proposed branch meet the definition of a branch office at 42 CFR 484.2? If it is possible to make a decision based on the provider's description of how it intends to operate, an onsite survey may not be necessary.

() If the proposal complies with State and local laws related to the particular type of provider/supplier; and

() Whether Medicare reimbursement is affected by the proposal. For example, a hospital states that it has purchased a physician's clinic that is now a part of the hospital. In such a case input from the Division of Medicare and the fiscal intermediary will likely be necessary. While HCFA does not dictate to a provider how it should operate its business, the provider does have to comply with Medicare requirements. Whenever an entity can meet the requirements of two different categories, e.g., sub-unit and independent home health agency, it is generally HCFA's policy to designate the category for which there is the least potential to increase Medicare costs. If a proposed branch is in an area that would receive a different payment rate than the parent HHA, it could be found to be in a different geographic area and determined not to be a branch.

Although legal authority exists for conducting a survey, a survey may not be necessary because the provider furnishes you with sufficient information to make a determination about its proposed expansion either at the time of its initial request or subsequently. If you believe a survey is required, but you are unable to conduct a survey within a reasonable period of time you may take one of the following actions:

() Make a determination based on the expansion information provided by the provider and inform the provider of the decision; and

() Inform the provider that a survey will be necessary and that it should not bill Medicare for services provided at the proposed expansion location until the survey is conducted and a determination is made.

In the absence of notification of an expansion, HCFA has the authority to deny bills for services furnished at the expanded site. When notification is received of a proposed expansion, the provider should be informed of whether the expanded site meets applicable requirements. The fiscal intermediary should be notified of the decision.

If you have questions or issues concerning this regional program letter, please contact our Chicago Regional Officer (312-886-9599).

/s/ Charles Bennett
Branch Manager, Program Support
Division of Health Standards and Quality